AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
CARE Level I and CARE Level II

I, _____, Social Security Number: __ __ __- __ __ - __ __ __ __ DOB ___/____/____
Name of client **[optional]**

hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that signing this form is voluntary. I understand by not signing this form I may experience a delay in accessing long term care and/or community services.

Providing the information:

Person(s)/Organization(s) (check all that applies)

_____ Community mental health center(s)
*Name*_____

____ Intermediate care facility/nursing facility/hospital
name _____

____ State institutions for mental retardation or mental illness
name _____

____ State psychiatric hospital(s)
name _____

____ Community developmental disability organization(s)
name _____

Other(s): name/address/phone_____

_____

_____

_____

_____

Receiving the information:

Person(s)/Organization(s) (check all that applies)

_____ CARE Program staff & affiliates

____ Area Agency on Aging: *Name*_____

____ Kansas Department for Aging and Disability Services

____ Kansas Health Solutions

____ Health care provider(s)/hospital/NF
*name*_____

____ Community mental health center(s)
name _____

____ State psychiatric hospital(s)
name _____

____ Community developmental disability organization(s)
name _____

Other(s): name/address/phone_____

_____

_____

_____

The purpose of the Use or Disclosure:

The CARE Assessment is in compliance with the State & Federal regulations governing Preadmission Screening & Resident Review (PASRR). A PASRR assessment is part of the pre-admission criteria to a Medicaid certified nursing facility in the state of Kansas.

The organization requesting this Release will not receive any financial or in-kind compensation in exchange for using or disclosing the health information described above.

The Individual or the Individual's Representative must read and initial the following:

- I understand that I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

- I understand this Release is valid for one year from today's date.

- I understand that I may revoke this Release at any time by notifying the providing organization in writing. It will not have an effect on actions that were taken prior to the revocation.

- I understand that if the person or entity that receives the protected health information is not a health care provider or a health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations.

- In understand that the Kansas Department for Aging and Disability Services will not condition treatment, payment, or eligibility for benefits on whether I sign this authorization except to the extent that the protected health information is solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____ _____
Signature Date

_____ _____
Signature of Personal Representative (if applicable) Description of Authority